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ABSTRACT

This report from the Alaska Pregnancy and Parenthood Task Force to the Alaska State Legislature presents the group's mission statement, their goals and objectives, and resulting recommendations on pregnancy prevention and prenatal and parenting services. The bulk of the report proposes and discusses the following recommendations: (1) fund a peer counselor program; (2) coordinate clinical, family planning, and prenatal services delivery; (3) require comprehensive school health education K-12; (4) conduct a statewide public awareness campaign and local prevention projects; (5) adopt a case management model for adolescent parents; (6) establish a day care assistance program; (7) increase qualifications and availability of day care providers; (8) educate and aid adolescent parents in obtaining quality day care; (9) implement day care centers in local schools or at coordinated sites; (10) identify the Governor's Commission on Children and Youth as the oversight body for implementation of the Adolescent Pregnancy and Parenthood Task Force recommendations; (11) encourage the Governor's Commission on Children and Youth to give more consideration to the needs of adolescents than has been given in the past; (12) provide adequate funding to school districts for school health services; and (13) develop a report on the costs of supporting adolescents and their offspring as compared to the costs of preventing adolescent pregnancies. (ABL)

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ALASKA'S ADOLESCENT PREGNANCY AND PARENTHOOD TASK FORCE

REPORT TO THE LEGISLATURE

January 1991

Co-Chairs:
Senator Drue Pearce
Representative Johnny Ellis

CG024503

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Judi Jordan also deserves our thanks. She was the staff person for the Task Force, did a great deal of research, made presentations before the Task Force, and coordinated meetings and the production of this report.

The following individuals made formal presentations to the Task Force, and we would like to thank them for sharing their expertise and their first hand knowledge of working with adolescents:

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EXECUTIVE SUMMARY

In 1989, Senator Drue Pearce introduced Senate Concurrent Resolution 38 which established the Adolescent Pregnancy and Parenthood Task Force. The Resolution passed the Legislature and was read into law (Legislative Resolve 101) in May of 1990. Recognizing the enormity and complexity of the problem of adolescent pregnancy in Alaska, the Legislature resolved to find ways to reduce the incidence of teen pregnancy and its social and economic effects.

Maureen Weeks, of the Senate Advisory Council, prepared a report for Senator Pearce titled "Three A Day: Children Having Children in Alaska." This referred to the fact that three adolescents give birth to babies each day in Alaska. The report revealed other startling facts. For instance, Alaska's adolescent birth rate is higher than rates in most other countries in the world including many undeveloped nations, and in 1985 Alaska's rank was higher than that of 41 other states.

The Task Force recognizes that the situation of adolescent pregnancy is not new nor is it unique to Alaska, and that no "quick fix" exists. It also recognizes that family and cultural values are important and should be preserved to the greatest extent possible. It is not the intent of the Task Force to ascribe "right" or "wrong" judgments about those adolescents who become pregnant. Rather, the Task Force wants to present recommendations that will allow teens access to the greatest number options their world has to offer.

The main body of the work performed by the Task Force took place in subcommittee. The Prevention Subcommittee focused on the prevention of adolescent pregnancy, while the Prenatal and Parenting Services Subcommittee concentrated on the care and services necessary to minimize the impacts once a pregnancy commences.

In addition, the Prevention Subcommittee recommends development of a Peer Counselor Program. This program introduces a local, relevant source of information and guidance, regardless of whether one lives in urban or rural Alaska. By its very nature the program is sensitive to the particular culture of the community and to the subculture of adolescence.

The Prevention Subcommittee further recommends increasing the availability and acceptability of family planning services to adolescents in every area of the state through coordination of delivery of clinical, family planning, and prenatal care services

to adolescents. Implementation would be through the Department of Health and Social Services.

Because the one word that surfaced again and again when discussing the prevention of adolescent pregnancy was education, the Prevention Subcommittee strongly recommends that each school district provide comprehensive, sequential, age-appropriate, culturally relevant, school health education in grades K-12. While the State Board of Education would establish the health education guidelines, local school districts would be responsible to establish the specific curriculum in their own districts with the help of a health education advisory committee. The topics to be addressed are so inclusive as to suggest a holistic approach to the well being of the child in defining his or her personal role as well as their larger role in the family and in the community.

The Prevention Subcommittee takes a page from the Division of Mental Health Suicide Prevention Projects when it recommends funding for small annual grants to communities. Adolescent pregnancy is a result of a complex combination of factors that vary greatly from one community to the next. Curing the problem and/or mitigating the impacts may be easier when local communities are allowed ownership of the issue and some flexibility in finding solutions.

In the discussions of the Prenatal and Parenting Subcommittee, they recognized that the families of teen parents are the major source of support, but the support system is usually strained beginning at the time when the pregnancy of a teen is discovered. This strain causes a crisis situation and the families own resources may be stretched by an unplanned child.

The first reaction of the family and the teen when they learn of the unplanned pregnancy may be embarrassment. A sense of isolation and increased tension within the family system usually follow. In their eagerness to do the right thing, parents often don't know what message to give their teen. They are torn between "you're on your own now" and "taking over."

All new parents regardless of their age need support. They need income, education, good health for themselves and their children, healthy behaviors, healthy families and good relationships. Many parents obtain that support from a spouse, parents, or other family members. Most adolescent parents each have some if not all of these supports.

A key component to good outcomes for adolescent parents is completion of at least a high school education. However, a barrier frequently stands in the way of completion of this level of education: day care for their child.

Therefore, The Prenatal and Parenting Subcommittee recommends that the Legislature fully fund the Day Care Assistance Program to assist all eligible families. Most adolescents who become pregnant have not completed high school and their prospects for graduation from high school are statistically low. One reason is that adolescent parents are currently low in priority for day care funding that would enable them to complete their education and subsequently to become employed.

Currently providers of day care do not meet the demand for child care needs, particularly for infants and non-standard care hours and days. In order to meet this need, the Prenatal and Parenting Subcommittee recommends that additional funding be provided to educate and train licensed and unlicensed providers, including those currently ineligible to participate in the Day Care Assistance Program.

Assuming that infant care is available, adolescent parents should receive information in how to identify quality day care for their child. The Prenatal and Parenting Subcommittee understood that by definition adolescent parents have fewer life experiences than more mature parents, and are less likely to know how to locate quality day care for their child.

Another source of day care for the children of adolescents, and perhaps the most accessible and reliable location, is in a day care center located within the high school. The availability of on-sight day care could prove to be the greatest motivating factor for an adolescent parent to complete their high school education.

A lack of familiarity with "the system" by adolescents and their families is one of the greatest deterrents to receipt of services to this group. Currently coordination of services and referrals is not being done, allowing pregnant and parenting adolescents to slip through the existing net of available services. Prenatal care, child support, AFDC, WIC, child care, education, employment, and transportation issues are examples of support services that may be a mystery to adolescent parents and their families. Therefore, the Prenatal and Parenting Services Subcommittee recommends the adoption of a "case management model" through contracts between the Department of Health and Social Services and local resource agencies.

The recommendations of the Task Force are not an end in themselves. Some organization or group should be designated to guide the recommendations of the Task Force through the legislature and the executive branch. The Task Force believes the Governor's Commission on Children and Youth was set up to deal with the problems of all of Alaska's children including adolescents and is, therefore, the logical and best qualified

organization to follow up on the recommendations of the Task Force.

Having made that recommendation, the Task Force encourages the Governor's Commission on Children and Youth to give more consideration to the needs of adolescents than has been given in the past. Increased emphasis might be accomplished through replacing retiring members of the Commission with appointments of individuals having the problems of adolescents as their primary interest and/or expertise.

The Task Force believes that every child in Alaska deserves the opportunity to lead a healthy and productive life. From research undertaken by the Task Force, members have concluded that offering school based health clinics is the most effective way to ensure that the largest number of children have that opportunity. Clinics in each school district would offer counseling on healthy life skills and family planning, physicals, immunizations, and treatment for acute and minor injuries and illnesses.

In evaluating information and recommending solutions, the Task Force acknowledges that some of its recommendations may be controversial. Some may even say that the cost of implementing the recommendations is too great. However, when one considers that federal, state, and local governments pay more than $51 million a year to support needy families of Alaska mothers who had children when they were teenagers, the cost of implementing the recommendations of the Task Force assume minuscule proportions.

In order to have firm data on <u>all</u> of the costs to society of supporting adolescent parents and their offspring, the Task Force recommends that the Institute for Social and Economic Research develop a statistical data base on these costs. This information is necessary to provide baseline data to be used in justifying state expenditures for the prevention of adolescent pregnancy and the benefits of supporting services for parenting adolescents and their children. In addition, it would provide standards for measuring program effectiveness.

The Task Force has not prioritized its recommendations because they are presented as a total program. All are equally important in the full picture. While any one recommendation can stand alone, adolescent pregnancy is a multifaceted problem which requires a multifaceted approach.

There are three sets of recommendations. Four come from the Pregnancy Prevention Subcommittee; five from the Prenatal and Parenting Services Subcommittee; and, the full Task Force provided an additional four recommendations. All of the recommendations were approved by the full Task Force.

INTRODUCTION

As Mandated by Alaska Statute, Legislative Resolve 101, the Adolescent Pregnancy and Parenthood Task Force presents the following recommendations to the 17th Legislature of the State of Alaska.

The purpose of the recommendations is to improve the delivery of services to pregnant and parenting adolescents and to reduce the rate of adolescent pregnancy in Alaska.

Background:

The Alaska Legislature passed Senate Concurrent Resolution 38 in May of 1990 and created the Adolescent Pregnancy and Parenthood Task Force of Alaska. The purpose of the Task Force was to:

1) gather additional evidence and testimony on the extent and effects of adolescent pregnancy and parenthood in Alaska;

2) review options and recommend a statewide plan with guidelines for implementation to reduce the rate of adolescent pregnancy in Alaska;

3) examine existing state and local programs and services in Alaska and in other states and recommend ways to improve the delivery of information and services for the prevention and medical treatment of adolescent pregnancy in Alaska;

4) examine the relationship between the issues of adolescent pregnancy, alcohol and drug use by adolescents before and during pregnancy, and the effects of alcohol and drug use on the health of the parents and the child;

5) recommend ways to inform children and young adults about the consequences of early parenthood, including information about child support obligations for both parents and their other rights and responsibilities.

The Task Force began meeting in late August of 1990 and held six statewide teleconferenced meetings before presenting this report in its final form for consideration by the Legislature.

With the help of over 200 individuals representing organizations from all across the state, the Task Force was able to develop its recommendations which considered the opinions of a wide range of individual interests. The Task Force membership and participants represented all walks of Alaskan life from health care providers from the bush communities to the commissioners of state departments. In the formal committee, there were fifteen Task

Force members. They were joined by a concentrated working group of approximately 30 individuals.

In October, the Task Force divided up into two subcommittees: the Prenatal and Parenting Services Subcommittee; and the Pregnancy Prevention Subcommittee. In November these two subcommittees began drafting their recommendations and continued to do so at their December meetings. In January, the subcommittees presented their recommendations to the full Task Force for a vote on those to be included in this final report to the Legislature.

MISSION STATEMENT

The Task Force will make specific recommendations regarding the prevention of adolescent pregnancy and will recommend ways to mitigate the impacts of adolescent pregnancies when they occur.

In the course of developing recommendations, the Task Force will gather information, review options, examine existing state and local programs and services in Alaska as well as in other states, and will examine the relationship between adolescent pregnancy and drug and alcohol abuse.

GOALS AND OBJECTIVES

Considering the mandates from the Alaska Legislature, the Adolescent Pregnancy and Parenthood Task Force identified the following as its Goals and Objectives:

1) identify strategies that have proven successful in preventing teen pregnancy;

2) choose the mix that best fits Alaska;

3) determine what type of programs already exist in Alaska and how to build on that base by introducing new methods or programs;

4) identify teen parent support efforts presently in place;

5) note the barriers to receiving support and determine how to remove those barriers; and

6) identify methods to avoid subsequent pregnancies.

While the Task Force was mandated to "examine the relationship between the issues of adolescent pregnancy, alcohol and drug use by adolescents before and during pregnancy, and the effects of alcohol and drug use on the health of the parents and the child", they decided that this mandate was best addressed by the Task Force on Fetal Alcohol Syndrome.

RECOMMENDATIONS PROPOSED BY THE

PREGNANCY PREVENTION SUBCOMMITTEE

RECOMMENDATION:

The State should fund the development of a Peer Counselor Program.

Issue

All across the state, and more frequently in rural areas, access to services is lacking or insufficient. In both rural and urban areas of Alaska, adolescents do not know where to receive services or advice on healthy life skills, pregnancy prevention, contraceptive services, and/or prenatal care. They frequently delay taking positive action in particular for prenatal care because they are uninformed about how to utilize existing programs. Because adolescents frequently go to other adolescents for advice rather than to adults, the Task Force recommends the development of a Peer Counselor Program.

Implementation

The Department of Health and Social Services should be mandated to provide training coordinators for peer groups selected from each community. The training coordinators would:

1) conduct training sessions to:

   a) develop interpersonal communications skills;
   b) teach accurate health information, emphasizing sexual development; and
   c) provide information about services available in their areas and how to access those services for pregnancy prevention, prenatal care, and healthy life skills.

2) be readily available to the peer counselors to answer specific questions and provide supportive counseling; and

3) provide updated information for the peer counselors.

Cost

For program development, training of the training coordinators, provision of materials, and operation for the first year the cost would be approximately $300,000. Costs for future years program operations would be considerably less.

Benefits

The establishment of a statewide peer counseling program focused on reproductive health needs would ensure, 1) the dissemination of accurate information regarding human reproduction, and 2) timely referral to professional services. From time immemorial, adolescents have shared information about sexual development and reproduction, the classical "back behind the barn" conversation. The peer counseling program would tap into this time honored ritual, but this time the information would be accurate and appropriate. Teenagers who are reluctant to approach adults would now have access to adult wisdom and support through trusted and knowledgeable peers.

This increased access to information and available services has far reaching potential. Accurate information regarding family planning and support of abstinence would decrease the number of unplanned teen pregnancies, thus reducing the tax burden upon the state of Alaska. The dissemination of accurate health information and concomitant referral service would reduce the social and economic cost of obstetrical and gynecological care through early intervention in life threatening conditions such as ectopic pregnancy, preterm labor and delivery, and other medical emergencies. Reduction of sexually transmitted infections, and the resulting infertility, holds promise for our families of tomorrow. The soaring costs of medical care are most efficiently controlled through, 1) prevention, and 2) early detection and treatment. The peer counseling program is a tool to achieving both.

Development of a peer counseling program introduces a resident and constant source of information and referral in all our communities. This presence would not only be sensitive to the particular culture of that community, but to the subculture of adolescence. The information would be accessible and comprehensible. The resident resource is of special importance in our smaller communities where information is needed in a timely fashion, but it is not feasible to have professional services continually available in the community.

The training and responsibility of the peer counselor would also benefit that specific adolescent, giving him or her additional education and responsibility. Additional education is a factor known to be associated with a delay in the onset of sexual activity and pregnancy.

RECOMMENDATION:

Mandate that the Department of Health and Social Services coordinate the delivery of clinical, family planning, and prenatal care services to adolescents in all communities of the state.

Issue

Many Alaskan communities currently lack clinical, family planning, and prenatal care services. Without these servies, adolescents are often unable to receive needed education, contraceptives and care. While family planning counseling may be provided, the care providers are frequently not able to prescribe or provide contraceptives.

Implementation

1) In small rural villages itinerant medical care currently exists on a semiannual basis. These services must be augmented to include: an outreach component to encourage adolescents to visit the provider; and, provide educational information in a non-threatening and positive environment. This could be accomplished by the addition of health educator services to physician care or in a more cost efficient manner by utilizing mid-level practitioners who are competent in clinical, educational, and outreach services. Since the target population is adolescent girls, a female clinician would be the most appropriate service provider.

2) In larger rural communities, clinicians employed or contracted by the state should visit a minimum of once per month throughout the year, providing outreach and clinical services.

3) Urban communities should receive augmentation of current services as needed. This need would be assessed by the Maternal Child and Family Health Section of the Department of Health and Social Services.

4) The Section of Maternal/Child and Family Health shall facilitate the coordination between all existing providors.

Cost

The estimated cost of this recommendation is $500,000 in the first year for clinician time, travel and per diem. Future years may differ.

Benefits

Tying provision of family planning, prenatal, and health screening services to health education and outreach would increase the likelihood of these services being utilized.

Increasing the availability and utilization of clinical care, especially in our rural areas where the teen birth rate is the highest, would reduce the number of unplanned pregnancies and their resulting social and economic costs. The expanded use of routine screening exams would aid in the early detection and treatment of many reproductive diseases, such as cervical cancer which is picked up by the common and cost efficient pap smear. Increased utilization of prenatal care would reduce the costly occurrence of preterm delivery and complications of child birth more common among adolescent mothers.

Increasing the availability and acceptability of family planning services to adolescents would logically reduce the teen pregnancy rate. This would result in obvious savings in medicaid and AFDC payments. It would also result in less obvious savings: teen pregnancies are more likely to produce babies with medical needs that then become a tax burden and/or aid in the escalation of medical and health insurance costs. These medically compromised newborns are more likely to grow up into minimally productive or welfare dependent adults, thus adding to the burden of future generations. Adolescent parents are also more likely to raise children who then become teenage parents themselves with all its associated problems. We can break this socially, spiritually, and financially expensive cycle with a multifaceted, comprehensive approach. Increased availability of family planning services is a logical and essential part of any plan.

RECOMMENDATION:

Require that each school district provide comprehensive, sequential, age-appropriate, culturally relevant, school health education in grades K-12.

Issue

Currently, Alaska Statutes encourage, but do not require, public school health and personal safety education. Although most school districts in the state report that they do have a "program" in health education, the instruction in many cases tends to be sporadic, incomplete, culturally insensitive, and/or taught by teachers lacking appropriate training in health education. Often, reproductive health issues are omitted altogether. In general, youth have no opportunity to become informed about inter-related health issues, nor to learn skills to enhance their health and prevent a variety of self-defeating events, including adolescent pregnancy.

Implementation

1) The health education curriculum guidelines will be established by the State Board of Education, but the specific curriculum will be developed by each school district.

2) Each school district must establish a health education advisory committee.

3) Regardless of specific curriculum, the following topics will be addressed:

a) community health
b) consumer health
c) dental health
d) family health and human sexuality
e) human growth and development
f) mental and emotional health, including suicide prevention
g) nutrition
h) personal health and physical fitness
i) prevention and control of diseases
j) safety first aid and injury control
k) substance use and abuse, including alcohol and drug related birth defects

4) Districts' programs will include specific ways to assist parents and other members of the community to participate in health and personal safety education.

5) Parents or guardians will have the option to exempt their child from part or all of the reproductive health portions of the curriculum. If exercising this option, the parent or guardian must make arrangements for the student to acquire the knowledge in some other way. All students will be required to pass an examination on this portion of the curriculum.

6) An in-service program which includes age-appropriate information about student pregnancy, student health issues and local community health resources shall be required. In addition, training and periodic staff development for administrators and teachers will be provided.

7) A transition period for implementing the health curriculum in schools will be determined by the State Board of Education.

Cost

Funding for the implementation of this recommendation could be accomplished through: 1) local district funds; 2) increased foundation funding; 3) increased categorical funding; or 4) a combination of any of the three.

Benefits

In the short term, a required K-12 sequential, comprehensive, health education program in schools will maximize the likelihood for youth to acquire the knowledge and skills necessary for living healthy, stable lives. When given the opportunity to learn about health with peers in school, especially when combined with interaction with parents and/or other caring adults, more young people will be able to recognize and effectively deal with the circumstances in their lives which could lead to early pregnancy and related consequences. In addition, this is an opportunity for adults to become more involved and informed about children's issues and to develop their own skills in guiding youth.

The expected long term benefits of implementing this recommendation include a reduction of adolescent births (and adolescent pregnancies, although this cannot be adequately measured), more positive outcomes of adolescent pregnancies, and a population of future adults better prepared to contribute to the society in which they live.

RECOMMENDATION:

Mandate that the Department of Health and Social Services direct a statewide public awareness campaign and fund and monitor a program of comprehensive adolescent pregnancy prevention projects modeled after the Divisoin of Mental Health Suicide Prevention Projects.

Issue

The magnitude of the problem of adolescent pregnancy is a result of a complex combination of factors that vary greatly from one community to the next. These factors are diverse and cannot be solved by a single approach; therefore, this Task Force has learned that the most successful approach to solving the problem of adolescent preganncy will have to include a wide variety of programs and services. By forming diverse coalitions, respecting community cultures, and addressing adolescent pregnancy in context, set backs can be minimized and the potential for success maximized. Preventing adolescent pregnancy means changing the decisions adolescents make about sexuality and child bearing. These decisions are bound up in the adolescents ideas about family life, education, and their perception of their own ablities and opportunitites. A variety of other circumstances related to mental health, family violence, substance abuse, and community development alsoimpinge on the making of these decisions.

If the state is to reduce rates of adolescent pregnancy, it must employ a comprehensive approach. The various political entities must have the support and confidence of the public as a whole, and certainly changing people's values and attitudes takes time.

Implementation

1) The statewide public awareness campaign shall:

   a) coordinate all interested and appropriate agencies in the state;
   b) develop a multi-media program that communicates to the public the scope and magnitude of the adolescent pregnancy problem;
   c) call for volunteers from other state agencies as well as the private sector;

d) encourage community activities which will educate adults and adolescents alike about the importance of reducing adolescent pregnancy;
e) coordinates with existing programs for National Family Sexuality Education Month in October of each year.

2) Funded projects shall incorporate the following concepts:

a) Adolescent pregnancy addressed in a holistic context, recognizing the interconnectedness of adolescent pregnancy and a broad array of related circumstances such as:

1. low self-esteem
2. domestic violence
3. substance abuse
4. economic security
5. financial responsibility of bearing a child
6. cultural integrity
7. parenting skills
8. educational and vocational opportunities
9. access to reproductive health services

b) Projects will be defined and designed with maximum input from local community members who represent the variety of interests, cultures, and perspectives on teen pregnancy.

c) Projects should be based upon sound research, to the maximum extent possible.

d) Projects will maximize collaboration among all relevant agencies involved in the issues being addressed.

e) Projects will incorporate an evaluation component to measure project effectiveness.

f) Projects will include a public awareness campaign.

Cost

The cost of a statewide public awareness campaign would be dependent upon the complexity and type of media used. However, an adequate campaign could be mounted for approximately $100,000.

The cost of the community based projects is estimated to be much the same as those for the Suicide Prevention Projects and to be dependent upon the number of projects funded. At the very least, the Task Force recommends that various level grants be designed to meet the needs of rural, semi-rural, and urban communities.

According to the office fiscally responsible for suicide prevention projects, grants average $15,000 per year per project, and there are nearly 50 projects around the state. Grants are

given to communities who have developed a proposal for preventing suicide in their localities. A copy of a grant application for a suicide prevention project is included in Appendix B.

Benefits

Initially, the expected benefits include a greater focus on the problem of adolescent pregnancies in many communities, which itself would result in better clarity. In addition, strategies for preventing adolescent pregnancy that are relevant to individual communities would be developed and implemented, evaluated, and possibly shared with other communities.

Over time, the number of adolescent births (and pregnancies, although this cannot be adequately measured) would decline. Additional benefits, perhaps not directly related to adolescent pregnancy, such as enhanced cultural pride, greater local support for domestic violence victims, or improved vocational training opportunities, are also likely.

RECOMMENDATIONS PROPOSED BY THE

PRENATAL AND PARENTING SERVICES SUBCOMMITTEE

RECOMMENDATION:

Adopt the "Case Management Model" to serve adolescent parents.

Issue

All parents need support. They need income, education, good health for themselves and their children, healthy behaviors, healthy families and good relationships. Many parents obtain that support from a spouse, parents, or other family members. Most adolescent parents have some, if not all, of these supports.

The families of adolescent parents are the major source of support, but the support system is usually strained beginning at the time when the pregnancy of an adolescent is discovered. This strain causes a crisis situation, and the familie's own resources may be stretched by an unplanned pregnancy and child.

The first reaction of the family and the adolescent when they learn of the unplanned pregnancy may be embarrassment. A sense of isolation and increased tension within the family system usually follow. In their eagerness to do the right thing, parents often don't know what message to give their child. They are torn between "you're on your own now" and "taking over."

Because of the emotional immaturity of adolescent parents and an unfamiliarity with "the system" by the adolescents or their families, a situation may occur that interferes with using resources or acquiring resources that will mitigate the problems usually experienced by adolescent parents.

Prenatal care, child support, AFDC, WIC, child care, education, employment, and transportation issues are examples of support services and resources that may be a mystery to adolescent parents and their families.

The coordination of services and referrals is not currently being done. Most current case management services do not specifically address all the specialized needs of adolescent parents in all areas of the state.

Implementation

1) The Department of Health and Social Services should contract with local resource agencies to carry out a case management program for their localities.

2) In order for an agency to contract with the Department of Health and Social Services, the agency must agree to provide at a minimum the following services:

a) an evaluation of the needs of each adolescent seeking help;
b) a discussion of services available to the adolescent;
c) a list of service providers (AFDC, WIC, day care, 12 step programs, etc.);
d) transportation to these services, if needed;
e) help in completion of applications for services from other agencies;
f) follow up to insure that appointments are kept; and
g) continued assessment of the adolescent's needs as judged necessary for each case.

Cost

Medicaid offers case management to its clients. The cost estimate the Task Force reports here is based on the same figure used by Medicaid of $80 per month per adolescent. Alaska has approximately 1,000 adolescent births per year and approximately one-third of these adolescents could qualify to receive Medicaid coverage. For the remaining two-thirds the cost is estimated to be $640,000 for one year of case management and $1,280,000 if all cases are followed for two years.

Benefits

Case management for adolescent parents and pregnant adolescents would improve outcomes by providing built in, consistent support that would monitor the needs of the whole adolescent person, teach them how to access the community and services and enable them to make wise decisions. When there is lack of follow through or success by the adolescent, case management serves as a safety net to assist in reacting to the consequences.

RECOMMENDATION:

Fully fund the Day Care Assistance Program (DCAP) to assist all eligible families.

Issue

The Day Care Assistance Program (DCAP) is a subsidy program which assists in the cost of child care for low to middle income parents while they are working and/or training. Historically, the DCAP funds have not met demand within the state for parents needing assistance. The programs base funding level must be adjusted annually to meet the estimated demand. There are 294 families (464 children) currently on waiting lists statewide who will not be assisted this year.

Implementation

The Legislature should appropriate sufficient funds to eliminate the waiting list and to meet the needs of all parents qualifying for day care assistance across the state.

Cost

Full funding of the Day Care Assistance Program to include all families would cost approximately $2,000,000 in FY 1992.

Benefits

Full funding of the Day Care Assistance Program would allow adolescent parents, who are currently low in priority for day care funding, to continue their education/training. In the long run, this funding would reduce welfare costs for these individuals and their families by enabling them to become self-supporting and to get off the public assistance rolls by educating them so they could obtain higher levels of employment.

RECOMMENDATION:

Increase the qualifications and availability of day care providers.

Issue

Quality child care is another issue of major concern to federal, state and local child advocates. Currently providers of day care do not meet the demand for child care needs, particularly for infants and non-standard care hours and days. In order to meet this demand, DCAP needs funding to provide education and training for providers. Current statutes (AS 44.47.305(d)) limit participation in such training programs to those providers participating in the Day Care Assistance Program. In addition, individuals are frequently overwhelmed by the licensing process and give up before they get started. These individuals are in need of assistance in understanding how to meet day care licensing requirements.

Implementation

1) Change Alaska Statute 44.47.305(d) to allow for training of non-licensed day care providers and those not currently in the DCAP program.

2) Provide additional funding to prevent current DCAP providers from dropping out of the program.

Cost

Additional education and training of additional providers would require approximately $300,000 for FY 1992. Funding for the expansion of day care providers would require approximately $200,000 in FY 1992.

Benefits

With approximately 600 State licensed homes and centers and 276 military certified homes and centers plus the numerous employees working in these centers, the $200,000 would equate to a few

dollars per person per year at best but could prevent current care providers from dropping out of the system. Funding appropriate education and training activities is a method whereby large strides can be taken to increase quality care at a minimum cost.

RECOMMENDATION:

Educate and aid adolescent parents in obtaining quality day care.

Issue

Parent education is needed on "what" parents should look for in obtaining quality day care for their child. A media campaign and circulation of a list of items a parent should consider in selecting quality care is needed. Adolescent parents in particular lack this knowledge; therefore, assistance in locating quality child care should be made available to all families. Resource and referral agencies (newly formed on a major scale this year due to the federal Family Support Act (FSA) program) are mandated to provide this service to AFDC families. However, they are only available to subsidized families.

Implementation

1) The Department of Health and Social Services should coordinate the distribution of materials designed to educate adolescent parents on the selection of day care for their child.

2) Provide funding to allow the expansion of resource and referral agencies to include all families, not just AFDC subsidized families.

Cost

There would be a one time cost of $25,000 for development of materials. The expansion of the Resource & Referral Agencies to include all families would cost approximately $350,000 in FY 1992.

Benefits

While licensing staff are only on site once a year, parents are on site twice a day. They are the best ones to detect early problems if they are likely to be present. Adolescent parents are most in need of education in what to look for when seeking quality child care. They are the least likely to have the attitude, skills and knowledge to choose quality child care; however, through education, they will be able to make the best selection for their child.

RECOMMENDATION:

Implement day care centers in local schools or at coordinated sites.

Issue

Access to affordable child care in the state of Alaska is extremely limited, especially for infants. Adolescent mothers who desire to complete high school are often prevented from doing so by the lack of affordable, accessible, and acceptable child care services.

In spite of the second highest rate of adolescent pregnancy and the ninth highest birth rate in the nation, Alaskan schools have done little to address the needs of adolescent mothers. Professional attitudes, apathy, and demand on limited resources have prevented the development of drop-out prevention programs such as in-school child care.

The Task Force recommends that a financial incentives program be developed which would encourage the establishment of in-school child care where a need for such services exists.

Implementation

A grant pool should be established within the Department of Education to provide incentive grants for locally developed programs providing in-school child care. Grant applications could be reviewed by appropriate inter-departmental personnel, or a combination of the Governor's Interim Commission on Children and Youth and department personnel.

Regulations and grant application content should be developed encouraging the expansion of existing high school programs (i.e., home economics child care classes) in such a way as to minimize the need for extensive additional financial resources and allow for practical local options.

Cost

The amount made available in the grant pool could vary widely. It needs to be "new" money as the existent demands on DOE funds are extensive and are intensified by other recommendations in this report.

A $300,000 grant with preference given to $25,000 to $50,000 local grant requests would provide a reasonable start at encouraging programs statewide.

Benefits

The establishment of in-school availability of child care would remove a significant barrier to completion of high school education by adolescent parents. The benefit to the state is the reduced likelihood of a continuance of both the parents' and the child's dependence on public assistance as a result of lack of education. Inclusion of the parents and possibly other students in the child care program would provide substantive opportunities for meaningful parenting education.

School is a safe, familial place. To an adolescent mother who has just gone through the trauma of pregnancy and birth, a school setting may be the most likely setting for reconstruction of her life and goals.

Completing a high school education along with the job/career counseling offered by most schools, and learning better parenting skills, provides an opportunity to break both a cycle of poverty and inadequate parenting.

Addressing the needs of adolescent mothers benefits both the mother and the child, as well as the human and financial resources of Alaska.

RECOMMENDATIONS OF THE FULL TASK FORCE

RECOMMENDATION:

Identify the Governor's Commission on Children and Youth as the oversight body for implementation of the Adolescent Pregnancy and Parenthood Task Force recommendations.

Issue

The Task Force recommendations were designed to help Alaska's adolescents avoid pregnancy, as well as to help adolescents who do become pregnant to receive prenatal care and help in improving their parenting skills. However, simply making recommendations will not bring about the desired goals. If we stop here, without some organization pushing the recommendations through the legislature and through their implementation and follow up stages, the Task Force's efforts will have been wasted. Adolescents will continue to become pregnant, and the rate of adolescent pregnancy will continue to escalate.

Not all programs suggested here will be perfect, and none will be effective over night. Minor adjustments to programs will be necessary to assure their maximum effectiveness, and some organization must be responsible to see that these programs are both implemented and adjusted accordingly.

The Governor's Commission on Children and Youth was set up to deal with the problems of all of Alaska'a children, including adolescents; and as such, is the logical organization to follow up on the Task Force recommendations.

Cost

The Governor's Commission on Children and Youth has already set up a network to address problems of children in Alaska. Making use of this network and experience would be the most efficient means of assuring the effectiveness of the Adolescent Pregnancy and Parenthood Task Force recommendations. No additional cost to the State is anticipated.

Benefits

With an oversight agency such as the Governor's Commission on Children and Youth, all of the recommendations of the Adolescent Pregnancy and Parenthood Task Force can be coordinated. This will help assure that the duplication of services is minimized and those areas where services are lacking are covered. Since our recommendations include programs run at all levels of government, and involve private agencies and organizations as well as state agencies, the Chidren's Commission would be best qualified to coordinate the implementation of our recommendations. The Children's Commission was designed to represent all sectors.

RECOMMENDATION:

Encourage the Governor's Commission on Children and Youth to give more consideration to the needs of adolescents than has been given in the past.

Issue

The Task Force commends the Governor's Commission on Children and Youth for the efforts they have made in addressing the problems of pre-adolescent children. However, probably because the Commission feels the needs of younger children are more urgent, a proportionate amount of effort has not been given to the problems of adolescents. The Task Force encourages the Governor's Commission to go to the source of many of the problems they are having to deal with in addressing the needs of younger children. Many of these children are the product of adolescent parents. A significant number of adolescent mothers give birth to infants of lower birth weight and with more developmental problems than children of older parents. These offspring frequently suffer more from child abuse, neglect, lack of good nutrition, and financial instability. In addition, these children of adolescents are frequently more at risk of repeating the cycle of early pregnancy, of having lower self-esteem, and of having a higher school drop out rate.

Implementation

Replace retiring members of the Governor's Commission on Children and Youth with individuals having the problems of adolescents as their primary interest and/or expertise.

Cost

This recommendation should have no additional cost. It merely requests a more equal distribution of effort from the Governor's Commission on Children and Youth. That commission is already mandated to deal with the problems of all children, including adolescents.

Benefits

The Task Force believes that with more attention paid to the problems of adolescents in all areas of prevention and prenatal and parenting services, the greater the benefits to society. Alaska can reduce the $51 million a year it spends annually to support needy families of Alaska mothers who had children when they were teenagers and the $4 million a year spent to support parents who are still teenagers. While these figures cover only the costs of AFDC, Food Stamps and Medicaid, other costs such as those for child care, protective services for abused adolescent mothers and their children, housing and counselling can also be reduced.

RECOMMENDATION:

The State should provide adequate funding to school districts for school health services.

Issue

Every Alaskan child deserves the opportunity to lead a healthy and productive life. Health services and healthy life skills training are often not available to our children (particularly in rural Alaska). Members of the Task Force have come to the conclusion that school health services are important. These services need to be adequately funded, and yet they have suffered considerably from budget cuts in the recent past. The Task Force looked at various programs which provide health services to school aged children. Research from other states such as Oregon, Michigan and Arkansas demonstrates that school based health clinics may be the most effective way of assuring that the largest number of children can receive these services.

Implementation

1) School districts should provide needed health services by bringing services up to adequate levels.

2) The Task Force encourages local school districts to explore models from those states with school based health clinics and to establish such clinics where appropriate.

Cost

The State should fund the cost of upgrading school health services to a reasonable level. Funding could be accomplished through: 1) increased foundation funding; 2) increased catagorical funding; or 3) a combination of the two.

Benefits

We have the opportunity to impart to our children a higher sense of self-esteem, better decision-making capabilities, and career and interpersonal skills which will benefit them for a lifetime. These

skills will help give Alaskan children the ability to avoid many of the problems which they now face--for example, the ability to say no to drugs and the education to help reduce the incidence of sexually transmitted diseases as well as to avoid adolescent pregnancy and its associated consequences. School based health services would serve as reinforcement for the instruction students would receive during regular class time on healthy life skills, human sexuality, family planning, interpersonal skills, decision making skills and self-esteem building.

RECOMMENDATION:

Develop a report on the costs of supporting adolescents and their offspring as compared to the costs of preventing adolescent pregnancies.

Issue

Both the causes and effects of adolescent pregnancy and parenting are complex and far reaching. The state must examine not only the costs of preventing adolescent pregnancy and supporting adolescent parents, but must also examine the costs of not preventing these pregnancies and the generational cycle of poverty thus created.

Implementation

1) Request that the Institute of Social and Economic Research (ISER) establish and maintain a body of statistical information assessing the costs to the state of adolescent pregnancies in Alaska compared to the estimated cost of preventing these pregnancies and of promoting healthy life-styles in existent adolescent parent families.

2) Request that ISER prepare an initial report which projects comparative financial costs and social implications into the next century (at least a 10 year projection). Data should be maintained in such a way as to allow for the timely update of reports.

Cost

ISER estimates that the cost of this report would be approximately $75,000.

Benefits

The development of a comparative costs report would: 1) provide justification for state expenditures; 2) provide standards for the measurement of program effectiveness; and 3) provide data for public information and support of programs.

APPENDIX A

Alaska State Legislature

Senate Advisory Council

PO. Box V
State Capitol
Juneau, Alaska 99811
Phone: (907) 465-3114

August, 1989

Alaska has the second highest adolescent pregnancy rate, the sixth highest adolescent abortion rate and the ninth highest adolescent birth rate in the United States -- which has the highest adolescent pregnancy, abortion and birth rates of any industrialized nation in the world. The state's Alaska Native adolescent birth rate is more than double the national rate for all races and it is increasing, while other state and national rates are slowly falling.

The attached report, Three A Day: Children Having Children in Alaska, describes the extent and costs of adolescent pregnancy and parenting in our state. Three teenagers a day give birth in Alaska. One a day is between 15 and 17 years old; one a month is 14 or younger. Nearly one in five of these young women are having their second, third or even fourth children. Nearly three in five are unmarried and 96 percent of unmarried U.S. teenage mothers keep their babies. Since 1984, more than 2,500 children have been born in Alaska to mothers who are still not yet 20 years old today.

STUNTED LIVES

While adolescents in Alaska are bearing and caring for children, teenagers in other countries and other states are going to school and learning the work and life skills necessary to become self sufficient adults. Girls who have babies when they hardly more than children themselves frequently become permanent dropouts from school and society, dependent on government support. Their children are at risk for early death, abuse, school failure, injury, emotional difficulties -- and teenage parenting.

The poverty, absence of goals, and sense of futility frequently spawned by adolescent childbearing are also often its causes in the next generation. The infant for whom society has sympathy today may be the child-parent society blames in a decade and a half for yet another untimely pregnancy and birth.

A PROBLEM TOO COSTLY TO IGNORE

It costs more than $12,000 a year to provide basic public services (food, medical care and essential living expenses only) to one needy teenage parent with one child. Babies born to adolescent mothers in Alaska this year alone will cost $21.5 million in public assistance (1988 dollars) by the time they reach the age of 19. Every year, it costs more than $51 million to support needy families of Alaska mothers who had their first baby when they were under the age of 20.

These are conservative cost estimates which do not include any of the public services often needed if very young parents are to become self sufficient: remedial and special education for parent and child; foster care; physical and sexual abuse counseling; child care and transportation, among others.

SOMEONE'S DAUGHTER

A 15-year-old mother lives anywhere in Alaska. She is someone's daughter, impregnated by someone's son. She is urban or rural, poor or middle class. She can be your neighbor, your babysitter, your child. The attached report describes the risk of lasting negative consequences for both mother and child and current research into the causes of teenage pregnancy. It presents a range of workable solutions already in place in other parts of the United States.

A topic so personal, so intimate, so compelling is easy to describe but difficult to control. The intimidating search for solutions generates diverse opinions and sometimes heated controversy. This report offers suggestions by state and national teen pregnancy experts, examples of recent legislation and descriptions of public and private programs from other parts of the United States. But Alaska's geographic situation and demographic blend are unique among the 50 states and the sample of programs listed here is intended only as a springboard for the ideas of those who want to attack this important social problem in Alaska.

EXECUTIVE SUMMARY

INTRODUCTION

The introduction briefly summarizes the problems facing adolescents who bear children and the public cost of supporting those who cannot support themselves. A pregnant teenage girl and her boy friend play a cameo role. The introduction includes definitions of terms.

The paper shows the extent, the causes and the consequences of untimely pregnancy and parenthood. It presents options other entities have used to deal with what most authorities label a grave and growing social problem. So personal, sensitive and immediate a topic generates diverse opinions on how to solve it. The range of these sometimes disparate proposals is presented for discussion.

Chapter I: ALASKA PORTRAIT: SOMEONE'S DAUGHTER

Teen parenting is more than a distant symbol of hopelessness in an East St. Louis slum filling the television screen between advertisements on 60 Minutes. A 15-year-old mother lives anywhere in Alaska. She is someone's daughter, impregnated by someone's son. She is urban or rural, poor or middle class. She can be your neighbor, your child, your grandchild. This chapter is a portrait of nine young Alaska women who have recently faced the inevitable decisions which come with untimely pregnancy. Among the true stories told here: A 13 year old Alaska girl was pregnant in late 1988 with her second child; both children were fathered by her own father. A 16 year old recently

gave birth to her fourth child; abused, she abuses her own children. A 17 year old with her baby in her arms learned from a public health nurse that she was pregnant again. A college-bound senior who was so drunk the world seemed "warm and fuzzy" the night she got pregnant says she saw her childhood slip away with every push on the delivery table. She isn't going to college because she can't afford it -- "plus, where would I ever find the time?"

Chapter II: THREE A DAY: ADOLESCENT BIRTHS IN ALASKA

This chapter is of a statistical nature. The statistics, summarized, include:

One in eight female teenagers in Alaska becomes pregnant. One in 17 has a baby. Between six and seven Alaska adolescents a day become pregnant. Three a day have babies. Two births a day are to 18 and 19 year olds; one a day is to a teenager between 15 and 17; one a month is to a girl age 14 or younger. Of every 11 babies born in Alaska, one is the child of an adolescent mother. About one in five Alaska adolescents who give birth have already had a baby. More than 2,500 children have been born in Alaska to mothers who are not yet 20 years old today.

In 1985, Alaska had the second highest reported teen pregnancy rate among the 50 states and the ninth highest birth rate. Among every one thousand adolescent girls, four give birth in Japan, 51 give birth in the U.S., 60 give birth in Alaska and 110 give birth among Alaska Natives. Alaska's teen birth rate is more than 80 percent higher than that of the Yukon Territory, the state's nearest neighbor. Although adolescent birth rates are falling in the nation and in Alaska as a whole, they are rising among Alaska Natives. Nearly three fifths of Alaska adolescent mothers are unmarried when they give birth. The state keeps no record of abortions but national adolescent pregnancy experts estimate that 41 percent of Alaska teen pregnancies are terminated (very close to the national average).

Chapter III: IN ALASKA: THE PUBLIC COST

Because they are at risk to lack education and job skills, teenage parents may require public assistance for a number of years. U.S., Alaska and local governments pay more than $51 million a year to support needy families of Alaska mothers who had children when they were teenagers. Of this, $4 million is spent each year to support needy parents who are still in their teenage years today. Basic costs to support one needy teen mother and her child are more than $12,000 a year. Each cohort of babies born in one year will cost the public $21.5 million (1988 dollars) by the time the group reaches age 19.

These are conservative cost estimates. They include only Aid to Families with Dependent Children, Food Stamps and Medicaid costs. They do not include costs of pregnancies which end in miscarriage or abortion or costs of intervening to prevent repeat pregnancies in young girls who may be caught in unhealthy and sometimes incestuous cycles. Nor do they include costs of educating and training a teenage mother to enter the job market, costs of child care while the mother completes her education, costs of foster care if the mother is homeless, protective services for abused adolescent mothers and their children, housing, counseling and partial loss of mother and child as productive members of society.

In one typical month, 335 Alaska teenage parents and their families receive public assistance. Because teenage parents, like other welfare recipients, move on and off the public assistance rolls, the total number of Alaska adolescent-headed families receiving welfare in a year is larger than 335. The majority of Alaska teen heads of household receiving welfare in a typical month are 18 and 19 years old and have one child.

Chapter IV: STUNTED LIVES: THE CONSEQUENCES OF ADOLESCENT CHILDBEARING

The injuries inflicted by teenage childbearing are not confined to the youthful mother and her children. They spread outward to society and forward to succeeding generations. Every child needs certain opportunities in order to become a healthy, self sufficient adult. But children born when their parents are still children themselves may miss out. Parenting is a difficult enough task for anyone; it is much harder when attempted in the poverty, isolation, depression, hopelessness, marital instability and unpreparedness which beset many very young parents. Although not all offspring born to adolescents suffer stunted lives, statistics show that as a group, they are more likely than other babies to die before their first birthday, to be hospitalized and to die as children of injuries or violence. They display more physical, emotional, behavioral and developmental difficulties than do children of older parents. They are more likely to fail in school and to score lower on standardized tests. Finally, in a phenomenon that compresses generations, children of adolescents tend to become adolescent parents themselves.

The adolescent mother is more likely than other mothers to be single, poor, isolated, depressed and a school dropout. One authority says the suicide rate among teen parents is seven times that of teens who are not parents. Teen mothers are likely to have poor math and language skills and only half attain a high school diploma. They tend to have larger families and more closely spaced children than do older parents. They may be more authoritarian and rigid than older parents. One study shows they begin conversation with, talk to and look at their infants less frequently than older mothers.

Chapter V: THE CAUSES OF ADLESCENT PREGNANCY: A DOUBLE EDGED SWORD

Too-early pregnancy and parenting are linked to poverty, low academic achievement, unsatisfactory school experiences and a feeling of futility or hopelessness. Also implicated are the influence of the media, community attitudes and lack of positive communication with parents.

Chapter VI: WANTED: "A LEADER WITH GUTS AND COURAGE"

The litany of risks facing children of very young parents -- poverty, unemployment, academic failure, futility -- is similar to the list of circumstances which threaten to lead them into precocious parenthood. Without intervention, the child for whom the public has sympathy today may be the child-parent one blames for yet another early pregnancy in a decade and a half. This chapter presents concrete suggestions by two Alaska experts and numerous national experts on combatting the problems of adolescent pregnancy. The strategies, summarized, include:

* Show disadvantaged teenagers there are options other than too-early parenting by: teaching them life skills, social connectedness and parenting; providing adult mentors as examples; reducing the school dropout rate (Alaska ranks 41st among the 50 states in rate of high school students who graduate); and making school a more meaningful and more positive experience for marginal students.

* Help teens postpone sexual activity by: encouraging sex and family life education courses; teaching assertiveness and decision making skills; involving parents in decisions. Encourage the media, with its "pervasive influence" on adolescents to alter its message. Some experts find a

strong and growing sentiment that schools can do more to help teens delay pregnancy.

* Make alternatives to child bearing available to the pregnant adolescent. These include adoption and abortion.

* Help the family of the adolescent parent. Encourage child support enforcement (at a time when states are adopting "workfare" for young mothers, it is appropriate to consider something similar for young fathers, one panel of experts says); help the mother get education and job training so she can become self sufficient; provide child care and counseling; make school meaningful for the at-risk child. The public must make up-front contributions to a population in which we have only "punily and grudgingly" invested, says one advocacy group.

* Contraceptive education: cause or cure? Many national groups urge contraceptive education and counseling for adolescents who choose to be sexually active. Several experts suggest school-based clinics to provide comprehensive health care to the "most underserved" segment of our society -- adolescents. They say clinics on or near schools have the advantage of being accessible and of attracting males (for such needs as athletic physicals) as well as females. Other advocates object that "modern" sex education classes haven't worked, that promiscuity breeds psychological and physical harm, that birth control clinics for adolescents are the latest step in a movement to transform schools into social welfare agencies and that school health clinics are destroying the old morality of family, church and neighborhood.

The section begins with an historical overview. Sexual activity among unmarried adolescents rose dramatically in the 1970's and leveled off in the early 1980's. Indeed, so many more adolescents are sexually active that the pregnancy rate among all teenage women has increased although the pregnancy rate among sexually active teenagers has decreased. Birth rates among all adolescents have fallen, while birth rates to unmarried

adolescents have increased. Adolescent abortion rates increased sharply after 1973 but increased by less than three percent from 1980 to 1985.

The arguments against making contraceptives available to adolescents are offered by Barrett Mosbacker of the Family Research Council, Dr. Dinah Richards of the San Antonio Pregnancy Centers and Allen C. Carlson of the Rockford Institute. Arguments for making contraceptives available to sexually active teens are summarized from the National Research Council, the Children's Defense Fund, the Urban Institute, the Council of State Policy and Planning Agencies, the National Governors' Association and the Alan Guttmacher Institute.

Chapter VII: IDEAS

This chapter describes state and national programs to fight teen pregnancy. Names and addresses of programs are provided for those who might want to consider replicating ideas.

Chapter VIII: WHAT STATES ARE DOING

This chapter summarizes initiatives proposed and taken by individual states to solve the problem of teenage pregnancy. It is up to date to mid-1989.

Alaska State Legislature

Legislative Research Agency

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September 20, 1990

MEMORANDUM

TO: Senator Drue Pearce

FROM: Maureen Weeks MW
Legislative Analyst

RE: **Adolescent Pregnancy in Alaska: 1988 Update**
Research Request 91.007

This brief report updates statistics on births to Alaska adolescents in 1988, the latest year for which data are available. An expanded version was delivered orally before the Teen Pregnancy Task Force, August 21, 1990 in Anchorage. Statistics through 1987 can be found in *Three A Day: Children Having Children in Alaska*, published last year by the Senate Advisory Council at your request.

Numbers of births were provided by Al Zangri, Vital Statistics Research, Alaska Department of Health and Social Services; population estimates were provided by Greg Williams, Division of Research and Analysis, Alaska Department of Labor. In this memorandum, an adolescent is defined as a woman between the ages of 15 and 19.

Births v. Pregnancies

Because Alaska keeps no record of abortions among women of any age, no one knows how many pregnancies among adolescents end before term. Stanley K. Henshaw of the Alan Guttmacher Institute, which specializes in family planning issues, estimates that an average of one in every seven to eight Alaska adolescent females becomes pregnant. In 1988, one in every 17 gave birth.

Mr. Henshaw estimates that in 1985, Alaska had the second highest adolescent pregnancy rate (after California), the sixth highest adolescent abortion rate (after California, New York, New Jersey, Hawaii and Maryland), and the ninth highest adolescent birth rate (after Mississippi, Texas, Arkansas, Louisiana, Georgia, New Mexico, Arizona and Oklahoma.)

Number of Births to Adolescents in Alaska

In 1988, 13 girls under age 15 gave birth in Alaska. In that year, 334 babies were born to mothers age 15 to 17 and 702 to mothers age 18 to 19. In other words, in 1988, an average of almost two births a day were to mothers age 18 to

19, while almost one a day was to a mother from 15 to 17 years old. About once a month, a baby was born to a mother age 14 or younger.

Table 1, attached, shows the number of births to adolescents from 1982 to 1988. Although the number of births fluctuated from year to year, the total number fell from 1,235 in 1982 to 1,049 in 1988.

Rate of Births to Adolescents in Alaska

Definition

The number of births is useful when policy makers want to estimate demand for services, such as the number of adolescent parents who need welfare. However, the number tells nothing about the comparative size of the group of adolescent mothers. For that, statisticians prefer to use rate: the number of births per 1,000 adolescent females.

The difference between rate and number becomes clear when comparing Alaska, which has a small population, and New York, which has a large population. In 1985, some 25,500 New York adolescents had babies. This is a far higher *number* than the 1,099 Alaska adolescents who became mothers that year. However, among every 1,000 adolescents, there were 66 births in Alaska, compared to 39 in New York. Alaska's *rate* is higher, although its number of births is lower.

Alaska's Rate in 1988

In 1988, the Alaska adolescent birth rate was 58.1 per 1,000 adolescent females. This was higher than the 1988 U.S. adolescent birth rate of 53.6 per 1,000.

Table 2, attached, shows the Alaska adolescent birth rate for 1970 to 1988. The table shows that the Alaska rate has dropped from 93.9 births per 1,000 adolescent females in 1970 to 58.1 such births in 1988.

The Native Rate Compared to the White Rate

Alaska Native adolescents are far more likely to become mothers than are their white counterparts. In 1988, the birth rate among white adolescent females in 1988 was 44.9 per 1,000; among Natives, the birth rate was 111.3. In other words, an Alaska Native adolescent that year was about two-and-a-half times as likely to have a baby as was her white counterpart.

In 1988, Native teens of high school age gave birth to almost as many babies as did white teens, although there were far fewer Natives than whites in that age group. In that year, 172 babies were born to white mothers age 15 to 17 and 143 babies were born to Native mothers of the same age. Although the number of

births was roughly equal (separated by just 29 births), only one in five of all the girls in that age group were Native.

Table 2 shows birth rates for Alaska by race. In this report, race is limited to white and Native because the number of adolescent females who are black and other (Asian, Hispanic, etc.) is too small to be statistically significant.

The Alaska Native birth rate in 1988 was higher than the U.S. black rate, a rate which U.S. experts consider alarmingly high. The birth rate among Native adolescent females is so high that when we quoted it to experts at the Alan Guttmacher Institute, they believed (erroneously) that we were describing the Alaska Native pregnancy rate.

Trends in Birth Rates

Table 2 shows that between 1970 and 1988, the trend in birth rates dropped in Alaska and the U.S. Similarly, the trend among whites dropped during those years in Alaska and the U.S., as did the trend among U.S. blacks. The table shows, however, that the birth rate rose for Alaska Natives.

Rate of Marriage Among Adolescent Mothers in Alaska

In 1988, 62 percent of Alaska adolescent mothers were unmarried when their baby was born. Nationwide, 94 percent of unmarried teen mothers keep their babies.

Infant Mortality and Low Birth Weight Among Babies Born to Adolescent Mothers

In 1988, among every 1,000 babies born to Alaska adolescent mothers, 14.5 babies died before their first birthday, compared to 8.2 deaths among babies born to older mothers. Similarly, among every 1,000 babies born to Alaska adolescent mothers, 61.8 were low birth weight, compared to 48 low birth weight births among every 1,000 older mothers.

Attachments

TABLE 1
NUMBER OF RESIDENT BIRTHS TO ALASKA ADOLESCENTS, BY YEAR, 1982 - 1988
(Updates Table 4a, p. 160, Three a Day: Children Having Children in Alaska)

Age of Mother	1982	1983	1984	1985	1986	1987	1988
Under 15	11	13	8	13	12	10	13
15 - 17	332	348	314	318	343	351	334
18 - 19	889	809	884	788	708	724	702
Unknown	3	4	2	6	3	2	0
Total	1,235	1,174	1,208	1,125	1,066	1,087	1,049

Source. Division of Vital Statistics, Alaska Department of Health and Social Services.

Prepared by the Legislative Research Agency, September 1990 (91.007A).

TABLE 2
U.S. AND ALASKA ADOLESCENT BIRTH RATES, AGES 15 - 19, 1970 - 1988
(Updates Table 2a, p. 159, Three a Day: Children Having Children in Alaska.)

Year	Alaska			U.S.		
	All	White	Native	All	White	Black
1970	93.9	89.4	98.7	68.3	57.4	140.7
1980	63.4	53.1	97.5	53	44.7	100.1
1982	68.5	58.5	99.4	52.9	44.6	97
1984	67	53.4	115	50.9	42.5	95.7
1986	57.6	45.9	102.7	50.6	41.8	98.1
1987	60.3	47.2	110.5	51.1	41.9	100.3
1988	58.1	44.9	111.3	53.6	43.7	105.9

Sources. For Alaska births: Vital Statistics Research, Alaska Department of Health and Social Services; Alaska population and birth rate estimates from Division of Research and Analysis, Alaska Department of Labor. U.S. birth rates from National Center for Health Statistics.

Prepared by the Legislative Research Agency, September 1990 (91.007B).

APPENDIX B

January ___, 1991

Dear Reader:

There are three sections and three appendices in this packet.

•Section A explains how DHSS grants work.

•Section B describes the Community-Based Suicide Prevention Program.

•Section C contains the application itself, the questions you need to answer and the other things you need to send us (budget and various forms). It also includes an outline which can serve as a checklist to help you be sure you've sent everything we need. Section C is divided into three subsections. Be sure you complete the correct one.

- •C1 is for communities which had grants in FY91;
- •C2 is for communities which have never before had CBSPP grants; and
- •C3 is for communities which had CBSPP grants in FY89 or FY90, but NOT in FY91.

•Appendix A is budget instructions.

•Appendix B is about suicide prevention.

•Appendix C is DHSS grant regulations.

For those of you who've been participating in this program for a year or more, please be assured we want to continue your project. As long as your project has been active and valued by people in your community (and as long as you've been good about those monthly narrative and quarterly fiscal reports), you can feel reasonably confident of funds for FY 92. But, please remember there are other communities who'd like to take part as well. Be as stingy as you can with your budget.

For those of you who are new applicants, please don't be intimidated by the application. We really don't want a book, just enough words to indicate your community has really thought itself and about what it wants to do. And we really will give you all the help we can with the application. Just call 465-2195. If you request it, we will be able to send a trained Community Development Specialist to your community to assist you with planning your project and completing your application. Also, feel free to call any of the communities near you which already participate. Current project coordinators are a good source of help. If you're not sure of what communities are already participating, call us and we'll let you know.

We're looking forward to working with as many of you as the dollars will allow.

Yours,
Susan Soule
RuthAnn Ryder

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Required Forms Enclosed

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
STATE OF ALASKA

A. GENERAL INFORMATION

(1) ELIGIBILITY (WHO MAY APPLY)

Eligible applicants include private nonprofit corporations, Indian Reorganization Act and traditional tribal councils, city or borough governments, municipalities, schools, regional Native health corporations, other political subdivisions of the state, or a combination of these entities. (Proof of non-profit status is required: (see 7 AAC 78.030)

(2) DEADLINE FOR SUBMITTAL

To be considered for funding, applications must be post- marked, date stamped by an air courier, or received at the address provided below in A.3. by April 19, 1990. Hand-delivered applications will also be accepted at that 230 S. Franklin Street, Rm. 314 if received no later than 4:30 p.m. April 19, 1990. Proposals delivered by telefax will not be accepted.

(3) NUMBER OF COPIES AND MAILING ADDRESS:

Send the original and 2 copies of the application to the address below. If included with the proposal, an acknowledgement of receipt will be returned to the applicant. Proposals delivered by telefax will not be accepted.

Susan Soule, Coordinator
Rural & Native Services
P.O. Box H-04
Juneau, AK 99811-0620

(4) INQUIRIES

If you have any questions, please call Susan Soule at 465-2195.

(5) PROPOSAL COSTS

The Department of Health and Social Services will not be responsible for an applicant's expenses prior to the award of a grant. All costs of responding to this RFP, including travel expenses to attend Proposal Evaluation Committee meetings, are the responsibility of the applicant only.

(6) **ACCEPTANCE OF TERMS**

By presenting a proposal, an applicant accepts all terms and conditions of this request and those contained in 7 AAC 78, the Department of Health and Social Services grant program regulations. If a grant is awarded, the applicant's proposal will become part of the grant agreement. The applicant will be bound by what is in their proposal, unless the Department agrees that specific parts of the application are not part of the agreement.

Proposals and other materials submitted in response to this request become the property of the state and may be returned only if the state allows. Applications are public documents and may be inspected or copied by anyone after they have been scored and reviewed.

(7) **DURATION OF GRANTS**

We expect that funds will be available to continue this program in future years, but cannot guarantee that will be the case. Our intent is to fund any project which is active and in compliance with program reporting and evaluation requirements. However, we expect you, over time, to reduce your reliance on state funds by developing other sources of funds and stimulating volunteerism.

(8) **APPLICATION REVIEW**

Procedures - Upon receipt of the application, program staff will ensure that all the required material has been included. If material is missing, the applicant will be contacted and requested to submit it before the date of the review. Applications will be reviewed and evaluated in accordance with the criteria specified in section C, and in conformity with 7 AAC 78.100.

THE TEAM WILL PROBABLY REVIEW APPLICATIONS DURING THE WEEK OF MAY 6th. WE NEED TIME TO COPY AND MAIL APPLICATIONS TO TEAM MEMBERS. PLEASE MAIL YOUR APPLICATIONS AS EARLY AS POSSIBLE.

(9) **FINAL DECISION AUTHORITY**

The Commissioner of the Department of Health and Social Services will make the final decision on grant awards.

(10) **APPEALS**

An applicant or grantee may appeal any of the following decisions as per 7 AAC 78.310:

a. a final grant award decision under 7 AAC 78.090(a);
b. a decision to withhold payment under 7 AAC 78.200;
c. a decision of a grant agency to require a refund of grant money under 7 AAC 78.230; and

d. a decision to suspend or terminate a grant (7 AAC 78.290)

Applicants who want to appeal Department decision(s) must submit, within 15 calendar days after receipt of the administrative action or decision, a written request to the Commissioner for a hearing. The request must contain the reasons for appeal and cite the law, regulation, or department policy upon which the request is based.

The Commissioner will review the hearing request and, within 15 calendar days after receipt of the request, advise the appellant of its acceptance or rejection. If the appeal is denied a written explanation will be returned with the notice.

If the request is accepted, the Commissioner will appoint a hearing officer and schedule a hearing for the earliest possible time, not later than twenty (20) calendar days after the acceptance. The Commissioner will, at his/her discretion, arrange for the hearing to be held by teleconference.

The hearing officer will submit a transcript of the hearing, written testimony, and a written recommendation to the Commissioner, who will make the final decision on the appeal.

(11) NOTIFICATION OF GRANT AWARD

Within fifteen (15) days after the Commissioner's final decision applicants will be notified of the grantor's intent to fund their program. Following negotiated budget and program revisions, if necessary, applicants will be issued a "Notification of Grant Award". This formal notice will contain specific performance and reporting requirements consistent with the Department grant regulations 7 AAC 78.

(12) METHOD OF PAYMENT - GRANT PERIOD

Successful applicants will receive 50% of the amount of their award on or shortly after the approval of the applicants budget and receipt of the signed grant award notice.

All subsequent advances will be given upon our receipt of the appropriate quarterly fiscal reports and request for advance forms. We will withhold $1,000 from the last advance until we receive and approve your end of year program and fiscal reports. The grant year is from July 1, 1990 - June 30, 1992.

(13) FUNDS AVAILABLE

The average initial award has been around $15,000. In past years we have been able to increase awards during the year when funds are available and need and level of project activity justify the increase. We will consider requests over $15,000 (but not over $30,000) for one-time building renovation

costs and other special circumstances. Any request over $15,000 must be fully explained and justified. Other sources of funds and in-kind contributions must be shown.

(14) COMMUNITY DEVELOPMENT SPECIALIST (CDS) ASSISTANCE AVAILABLE

If your community would like assistance in coming together to plan and develop this application, please call Susan Soule at 465-2195. Up to the limit of funds available, we can arrange for a CDS to visit your community for a period of up to 5 days to assist you. The CDS will NOT write your application for you. The CDS will:

assist you in getting community input;
help with community meetings;
aid in transforming the communities ideas into actions plans;
help prepare the budget.

SECTION B. COMMUNITY-BASED SUICIDE PREVENTION PROGRAM DESCRIPTION

1. INTRODUCTION - DESCRIPTION OF THE GRANT PROGRAM

The Community-Based Suicide Prevention Program invites communities to work in partnership with the Department of Health and Social Services and other State agencies to develop community-based projects to prevent suicide and other forms of self-destructive behavior and to promote community and individual health.

The program is designed around the findings and recommendations in the report of the Senate Special Committee on Suicide Prevention. It provides funds to the communities of Alaska to develop and administer their own programs to address problems and promote health.

The funds are intended to support a wide range of project that can cut across traditional agency boundaries. The Senate Report stated that communities see problems as interrelated. Rapid changes in lifestyles, conflicts between competing value systems, communication problems across generations, alcohol abuse, lack of economic opportunity and many other factors are all seen as contributors to the feelings of despair and anger that underlie self-destructive behavior. Projects funded through this program can address the underlying contributors in an integrated, holistic way.

In order to encourage this integrated approach, the program is coordinated through the Division of Mental Health and Developmental Disabilities and managed by an Interdepartmental Team consisting of representatives from several DHSS divisions, the Departments of Community and Regional Affairs, Education, Public Safety, the Alaska National Guard and one public member. It's a cooperative effort in which state agencies and communities work together to solve problems and promote healing and health. Within the limits of regulation and fiscal responsibility the role of government is to provide resources, and technical and programmatic support to community designed and controlled projects. Evaluation and monitoring are thought of as a means of learning what approaches are most effective and how we can all best learn from each other.

COMMUNITY INPUT

Before completing this application, make every effort to get as much input from the community as possible. Hold several community meetings. Meet with different age, interest, church, school and service groups separately. Distribute questionnaires. Get the feelings and thoughts of as many people as you can, especially the people the project intends to focus on: youth, Elders, whoever. Not only does this give you ideas, but it also increases the sense of community ownership of and pride in the project. It makes it more likely people will come to project activities and more likely people will want to get involved in helping, both as paid staff and as volunteers. For continuing projects, it lets you know what activities have been most liked and most valued.

FUNDS

The application asks the people of your community to determine the activities that they believe will work to reduce self-destructive behavior and to increase community health. The program provides funds for the people of your community to work to carry out these activities. Funds can be used for salaries, stipends, supplies, travel to workshops or to bring workshop presenters to your community. Funds can also be used for rent, heat, lights, renovations and equipment. If you do need to renovate a building, we expect you to seek contributions from other sources (councils, local businesses) and to provide some volunteer labor. We will not award funds for major, expensive renovations or expensive equipment items.

For continuing projects, if you request an increase over your FY91 amount, be sure to clearly explain why the increase is necessary and what additional activities it will support. Think about whether your project will be able to fully operate during the summer. It is OK to operate for nine or ten months only, and to budget accordingly.

Please remember to include or update your plan for decreasing your reliance on these grant funds in future years. For instance, if your project includes craft classes, think about a plan for marketing the crafts and using some of the proceeds to help support the project.

PROJECT COORDINATOR

One of the keys to success identified by the ongoing program evaluation is choosing the right project coordinator. Among the successful coordinator skills and qualities identified are:

effective communicator;
good listener;
team player, works well with others;
focuses on needs and opportunities;
honest about failures;
accountable;
optimistic and
has a vision of how things could be.

It will help your project if you keep these qualities in mind when selecting your coordinator.

EVALUATION

We will be continuing the program evaluation this year and will need the cooperation of all participating communities. The evaluation will give all of us the information we need to make good decisions and to run effective programs. Thanks in advance for your help.

ASSISTANCE

If you have any questions or need assistance, please call 465-2195. If you would like a Community Development Specialist to travel to your community to assist you, please call as soon as possible.

Appendix B, About Suicide Prevention, is included to help you think about suicide prevention and the kinds of projects you might develop.

2. REVIEW CRITERIA

The Review Team will be using these criteria in considering your application. It will help you if you keep them in mind as you are completing your application.

CONTINUING (C1) APPLICATIONS

1. Is the project carrying out the activities planned?

2. Is there a high level of project activity in the community? Do people who travel to receive training share the benefits of that training with the community by conducting workshops, presentations or/and working directly with troubled individuals?

3. Is the project making maximum use of local and regional or/and statewide agencies?

4. Are signs of progress towards meeting goals identified?

5. Are problem areas identified?

6. Are any changes in project goals consistent to the overall purposes of reducing self-destructive behavior and increasing community and individual health?

7. Do the activities planned for FY92 reflect the assessment of the effectiveness of activities to date? Are major changes in activities noted and explained? Are the activities consistent with the goals?

8. Is the plan to develop additional sources of funding updated and reasonable?

9. Is there a high level of community involvement in the project in general and in the development of this application in particular?

10. Is the budget reasonable and fully explained in the budget narrative? Are any increases in funds directly linked to an increase in project activities? Are funds requested supplemented with locally raised funds or/and volunteers?

11. Has the project been in compliance with fiscal and narrative reporting requirements?

12. Has the project coordinated with other grantees through regional workshops, phone or written communications? Did the coordinator attend the coordinators conference?

REVIEW CRITERIA FOR NEW APPLICATIONS (C2)

1. If the application is from a community, is there clear evidence community members representing all groups and ages were involved in the planning and feel a sense of ownership of and commitment to the project?

   or

   If the application is from an agency, is it clearly submitted at the request of a community or communities who were involved in the planning? Does the plan "belong to" the community(s)? Will the community members do the work?

2. Does the applicant have limited access to other programs and services?

3. Does the plan focus on reducing self-destructive behavior through community-based and community managed activities?

4. Are the problems the community has experienced clearly identified?

5. Are community strengths clearly identified?

6. Is the project clearly described? Are goals and activities related to identified problems and strengths? Is the project logical and workable?

7. Are the costs realistic? Are most of the funds used for services and programs? Are administrative costs and costs related to renovations and equipment reasonable?

8. Are there plans to coordinate with agencies serving the community and with neighboring villages which have suicide prevention projects? Have there been communications with these agencies and communities as part of the planning?

9. Is the project likely to have a lasting positive effect on the health of the community and its members and on a reduction in the incidence of self-destructive behavior?

10. Is there a realistic plan for generating other sources of funds to support project activities.

REVIEW CRITERIA FOR APPLICATIONS WHICH HAD CBSSP FUNDS IN FY89 OR FY90 BUT NOT IN FY91 (C3)

1. Is there a complete discussion of what happened to the earlier project and why it was not continued?

2. Is there reasonable assurance earlier problems with the project will not re-occur?

3. Are there activities started under the earlier project that have continued despite the loss of CBSPP funds?

4. Is there clear evidence community members representing all groups and ages were involved in the planning and feel a sense of ownership of and commitment to the project?

5. Is the proposed project clearly described, logical and workable?

6. Do goals and activities focus on reducing self-destructive behavior through community-based and community managed activities?

7. Are the costs realistic? Are most of the funds used for services and programs? Are administrative costs and cost related to renovations and equipment reasonable?

8. Are there plans to coordinate with agencies serving the community and with neighboring villages which have suicide prevention projects. Have there been communications with these agencies and communities as part of the planning?

9. Is the project likely to have a lasting positive effect on the health of the community and its members and on a reduction in the incidence of self-destructive behavior?

10. Is there a realistic plan for generating other sources of funds to support project activities?

SECTION C THE APPLICATION:

C1 - QUESTIONS FOR COMMUNITIES WHICH HAD CBSPP GRANTS IN FY91

Please number your response and respond in the order given.

1. When (what month) did the project begin conducting activities?

2. Did the project coordinator change during the year? If so why? What is the name of the current coordinator?

3. If you received funds for building renovations, when did the work begin? When was the work completed? If the work isn't completed, explain why and when you expect it to be done.

4. Describe what your project has been doing in the community. For each activity tell us:

   how often it took place;

   About how many people attended each session and whether those attending were children, teens, young adults or adults;

   who lead or presented activity.

   FOR EXAMPLE:

   SEWING CLASS
   MET WEEKLY FROM OCTOBER THROUGH MAY
   8 TEENAGE GIRLS AND TWO ELDER WOMEN
   COORDINATOR

   SUICIDE PREVENTION WORKSHOP
   OCTOBER 6-8
   57 PEOPLE OF ALL AGES OVER THE 3 DAYS
   THE COUNCIL PRESIDENT AND COORDINATOR HOSTED THE WORKSHOP.
   MENTAL HEALTH CENTER STAFF AND TOM BROWN OF ANCHORAGE PRESENTED.

   MEN'S AND WOMEN'S SUPPORT GROUPS
   WEEKLY MEN'S GROUP 3-9, WOMEN'S GROUP 8-12
   PROJECT COORDINATOR AND MARY SMITH

   COMMUNITY NEWSPAPER
   MONTHLY

5. What outside workshops, programs and trainings have people attended? Tell who has attended and how they have shared what they learned with others in the community. Did the coordinator or another project representative attend the Coordinators Conference?

6. If the project employs counselors or crisis responders (paid or volunteer), describe what they have been doing. If possible, include the number of persons counseled and/or the number of crisis responses.

7. Describe the ways in which you are coordinating with the CBSPP projects. Note especially your role in your CBSPP regional workshop. If no regional workshop was held, explain why.

8. Describe the ways in which you are coordinating activities with or receiving support from local, regional or statewide agencies.

9. Describe any changes in your community that are relevant to this project, for instance voting to ban the importation of alcohol, receiving a grant that compliments the purposes of this one.

10. Were there any suicides in your community during the year? If so, how many? If you can, talk about how the community responded, if healing circles were held for instance, and how the project and its staff were involved in the response.

11. Tell us about the parts of the project that seem to be working best.

12. Tell us about any parts that are presenting problems and how you plan to address the problems.

13. Tell us about community and council involvement in and support for the project. Talk about attendance at activities, volunteers and whatever else that indicates that the community feels a sense of ownership of the project.

14. List project goals for FY92. Explain any changes from FY91 goals.

15. What activities are planned for FY92 (July 1, 1991 - June 30, 1992)? Note and explain any major changes from this year's activities. If you are asking for an increase in your budget, it's important that you explain what additional things you will be doing to justify the increase.

16. Describe how you plan to develop additional sources of funds for the project.

17. Describe how the community was involved in developing this application.

18. Describe any suggestions you have on ways in which the staff here in Juneau could be more helpful to you.

19. What additional training does your project coordinator need?

NOW TURN TO PAGE ___ FOR BUDGET INSTRUCTIONS AND A LIST OF OTHER ITEMS YOU MUST INCLUDE IN YOUR APPLICATION.

C2 QUESTIONS FOR NEW APPLICANTS

Please number your responses and respond in the order given.

1. Answer 1A if you are a city council, village council, IRA or Traditional council, or a local village non-profit corporation submitting an application for your community.

   Answer 1B if you are a regional non-profit or statewide entity submitting an application on behalf of one or more communities.

1A **Who are you?**

It will help those of us reviewing your proposal to better understand your project and why you want to do it if we know some things about your community. Get input for your answers from as many people in your community as possible, ideally, through a community meeting.

Answer all the questions, but do not feel you have to write a book. A page or two will do.

Describe the community: include location, population, cultural groups.

Describe the lifestyle of the community, such things as subsistence activities, recreation, how people spend their time and how different groups in the community get along. Mention the kinds of jobs that are available and if more jobs are needed.

What social and health services are available? Do these services adequately meet the needs? If not, why not?

Describe the weaknesses and problems that exist in the community.

Describe the strengths the community has, the things people are proud of.

Describe the specific group that is applying for this grant. Who are you? How and why did you come together and decide to do this project. Be sure to state clearly the entity which will receive the funds and be responsible for the financial working of the project, including completing the required fiscal reporting forms.

1B. **Who are you?**

Briefly describe your agency. Give information which supports its qualifications to conduct this project, including past accomplishments, staff qualifications and experience.

Discuss your relationship, present and past, with the community or communities for which you are submitting an application.
For each community for which you are submitting an application answer the following:

Describe the community; include location, population, cultural groups.

Describe the lifestyle of the community, such things as subsistence activities, recreation activities, how people spend their time and how different groups in the community get along. Mention the kinds of jobs that are available and if more jobs are needed.

What social and health services are available? Do these services adequately meet the needs? If not, why not?

Describe the weaknesses and problems that exist in the community.

Describe the strengths that the community has, the things that people are proud of.

Describe the specific group within the community that worked with you to put together this project and complete this application. How did your organization come to be involved?

2. Explain the problems or problems you want to address. Explain how the problem is related to suicide and self-destructive behavior.

3. Describe your proposed project. What activities will take place? Who will conduct them? Will there be any training? If so, who will be trained to do what?

4. List and describe the goals of your project, what you hope it will accomplish.

5. Explain how you will evaluate your project; how you will know if it is working as planned in terms of activities and goals.

6. Describe how you will get started, what you have done so far and the first few things you will do if you receive an award.

7. When your program is fully operating, what will it look like?

   Describe a typical day, program, or week. Give examples of activities, programs who will do the work and who will be attending or taking part.

8. Describe how the community has been involved in planning and supporting this project.

   Attach letters at the very end of this application.

9. Describe how you will coordinate with agencies that serve your community and with neighboring communities which have suicide prevention projects.

   Note any discussions you have already had with agencies and other communities.

NOW TURN TO ___ FOR BUDGET INSTRUCTIONS AND A LIST OF OTHER ITEMS YOU MUST INCLUDE IN YOUR APPLICATION.

C3 QUESTIONS FOR COMMUNITIES WHICH HAD CBSPP FUNDS IN FY89 OR FY90 BUT NOT IN FY91.

1. In what year or years did your community have CBSPP funds?

2. Is the group applying (tribal council, city council, non-profit) the same as the group that had funds earlier? Explain.

3. Describe the goals and activities of the earlier project.

4. Explain why the project was not continued including why the community chose not to reapply or why the Interdepartmental Team recommended against continued funding.

   In your discussion of "why", be sure to fully discuss the problems experienced.

5. Talk about how you will insure the problems experienced in the past do not re-occur.

6. Describe any activities started under the earlier project that have continued without CBSPP funding.

7. Describe your proposed project, including activities and who will conduct them, training and who will be trained.

8. List and describe the goals of your project, what you hope it will accomplish.

9. Explain how you will evaluate your project; how you will know if it is working as planned in terms of activities and goals.

10. Describe how the community has been involved in planning and supporting the proposed project. Attach local support letters to the end of your application.

11. Describe how you will coordinate with agencies that serve your community and with neighboring communities which have suicide prevention program funds.

12. Describe your plan for developing other sources of funds for this project.

NOW TURN TO PAGE ___ FOR BUDGET INSTRUCTIONS AND A LIST OF ITEMS YOU MUST INCLUDE WITH YOUR APPLICATION

BUDGET: HOW MUCH WILL YOUR PROJECT COST?

Figure out your budget and put it in the form required by the Department of Health and Social Services:

BUDGET SUMMARY with costs shown by category

and

BUDGET NARRATIVE which explains each cost.

Detailed instructions are included in APPENDIX I, including a sample Budget Summary and Budget Narrative.

ASSURANCES

These are listed on the next pages. You must enclose a signed copy with your application.

CONSENT TO SUIT

The Attorney General's Office requires Native Council to complete and sign the Consent Suit form. Please submit this with your grant application. It's on the page following Assurances.

GRANT APPLICATION COVER SHEET

This is on the page after the Consent to Suite. Be sure to fill it out and make it the first page of your application.

ACKNOWLEDGEMENT AND RECEIPT

This is the last form. If you want us to let you know we received your application, fill it out and we'll mail it back to you. DON'T STAPLE IT TO YOUR APPLICATION. Just leave it loose on top.

LETTERS OF SUPPORT

You can attach letters of support from Regional mental health or/and alcohol programs, school personnel, village residents, residents or councils from neighboring villages. You SHOULD attach letters from agencies with whom you plan to coordinate activities

COMMUNITY-BASED SUICIDE PREVENTION PROJECT

APPLICATION OUTLINE AND CHECKLIST

Please use this outline to make sure you've answered all the questions and enclosed all the necessary forms.

Acknowledgement and receipt (one copy only, loose on top)*

Grant Application cover sheet - signed*

NARRATIVE

1. Answers to all questions in C1, C2 or C3, numbered.

BUDGET NARRATIVE

BUDGET SUMMARY

SIGNED ASSURANCES*

CONSENT TO SUIT (Tribal Councils only)*

SUPPORT LETTERS

These forms are enclosed with the application

APPENDIX A

GRANT BUDGET PREPARATION GUIDELINES

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APPENDIX A

DEPARTMENT OF HEALTH & SOCIAL SERVICES (DHSS)
Division of Mental Health & Developmental Disabilities (DMHDD)

GRANT BUDGET PREPARATION GUIDELINES

GENERAL INFORMATION

1. As part of your grant proposal, you must include both a BUDGET SUMMARY and a BUDGET NARRATIVE. The following pages of information are guidelines to help you complete them.

2. If you are in doubt about whether a cost will be permissible, or the correct placement of a cost, contact:

   Susan Soule
   Division of Mental Health & Developmental Disabilities
   P.O. Box H-04
   Juneau, AK 99811-0620
   (907) 465-2195

3. Round off figures to the nearest whole dollar and check your addition.

4. DHSS grant funds are not available for the following costs under any circumstances:

   a. Interest costs on loans;
   b. Contingencies;
   c. fines, penalties, bad debts;
   d. contributions or donations;
   e. entertainment, including luncheons, banquets, gratuities or decorations.

5. Use of DHSS grant funds is not normally permitted for the following costs UNLESS, after submission of full justification by the Grant Applicant under exceptional circumstances, funds are specifically approved by the Grantor in the Notification of Grant Award:

   a. purchase or construction of land, buildings, or improvements;
   b. payment of real estate mortgages or taxes;
   c. dues to organizations or federations;
   d. purchase of motorized vehicles.

6. Throughout these budget guidelines, the Department of Health & Social Services, Division of Mental Health & Developmental Disabilities, will be referred to as the Grantor; the village, council, group, writing the grant will be referred to as the Grant Applicant.

BUDGET SUMMARY

1. In this summary, Grant Applicants must outline the budget and all sources of funding.

2. An example of the format is attached. Specific forms are not provided, but please use this format - it will make it much easier to read.

3. Cost Categories (vertical - down the page): Identify and separate costs under the following categories:
   - 100 Personal Services
   - 200 Travel
   - 300 Facility Expenses
   - 400 Supplies
   - 500 Equipment
   - 600 Other
   - 700 Indirect Costs

4. Source of Funding (horizontal - across the page): A project may have several sources of funds in addition to these requested grant funds (such as Local/City, In-Kind contributions, Other federal or state funds, donations, etc.).

5. The balance of the information for this Budget Summary section is devoted to explaining the Cost Categories and examples of items for each category.

Information and Examples for Cost Categories

100 PERSONAL SERVICES

Salaries & Wages for project staff, temporary, and/or occasional employees, and who will receive fringe benefits. (Note: consultants and all other persons who will NOT be paid fringe benefits should be listed under category "600 Other").
Fringe Benefits such as federal withholding tax, Social Security tax, workmen's compensation, FUTA tax, etc. Also, include the fringe benefits percentage rate (%).

200 TRAVEL

Allowable costs include airfare, taxi, automobile rental, private vehicle mileage, ad per diem. Airfare must be less than first class rate whenever available. Automobile mileage is calculated at the State rate of 30 cents/mile. Per diem is for all travel outside the local community; the State rates vary according to the following geographical areas:

Southeast Alaska: $110.00/day
Includes Ketchikan, Wrangell, Petersburg, Sitka, Juneau, Glacier Bay, Haines, Skagway, etc.

Central Alaska: $115.00/day
Includes Anchorage, Mt. McKinley National Park, Prince William Sound, Kenai Peninsula, etc.
Far North Alaska: $100.00/day
Includes Fairbanks, Nome, Prudhoe Bay, North Slope, etc.

300 FACILITY EXPENSE

Allowable expenses include costs of renting/leasing office space, utilities, repairs, communication costs (telephone, postage, expenses), and renovations. The Grantor generally will not pay for both rent and renovation costs. Money for renovations should be itemized to show costs (example: $500 repair roof; $250 new sink; $100 replace broken windows).

400 SUPPLIES

Allowable costs include office supplies, program supplies (arts, crafts, posters, videos, pamphlets, etc.), household supplies and cleansers, medical supplies, food (when used only for grant project operations and not for celebrations or coffee breaks, etc.).

500 EQUIPMENT

Maintenance and repairs of equipment that is owned, leased or rented (typewriters, copy machines);
lease or rental of equipment (typewriters, audio/visual equipment);
purchase of equipment with a unit cost of more than $300 OR a useful life expectancy of more than one year (VCR, television, file cabinets, appliances, chairs). Include estimated shipping costs when appropriate.

Bids from a minimum of three (3) vendors must be obtained for any item costing over $300 (save and submit the paperwork for this!).

600 OTHER

Professional fees and costs associated with bringing a program consultant to your agency to provide training, workshops, and lectures.
Subcontracts to another agency for the provision of services. The conditions that apply to any proposed subcontract are:

a. The Grant Applicant must describe the basis for the total subcontract cost listed in the cost category.
b. Each subcontract must have the approval of the Grantor before any work begins and before any funds are encumbered or spent.
c. The subcontractor must conform to the same laws, regulations, and policies as the Grant Applicant regarding the use of State funds.
d. The Grant Applicant is responsible to the Grantor for the subcontractor's performance under the subcontract.

Other allowable costs include subscriptions to journals, insurance and bonding, and printing/advertising when done by an outside firm.

700 INDIRECT COSTS

Indirect costs are those costs incurred by a grant applicant agency that administers various program activities and as a result generates costs which are either difficult or impossible to attribute to a single program activity. It is the policy of the Grantor under 7 AAC 78.160 to accept the most recent federally negotiated indirect cost rate. The Grant Applicant must document the federal indirect cost rate by attaching a copy of the rate agreement to the Budget Narrative.

APPENDIX B

A Way of Thinking About Suicide Prevention and the Kinds of Projects You Might Develop

Human beings have certain NEEDS which must be met if they are to be able to live meaningful and rewarding lives.

Each of us needs - Positive sense of self - I like me, I'm an ok person. There are some things I do well.

Relationships - Others like me, I have friends, I'm connected to my family, community and culture, I belong.

Power - I can fix things that go wrong in my life, I have some control over how my life will go. I have a future and I can shape what that future will be like.

These needs are met or not met as we live our lives and interact with our ENVIRONMENT.

ENVIRONMENT IS THE WORLD OF FAMILY, COMMUNITY, SCHOOL, FRIENDS, CULTURE, COUNTRY IN WHICH WE LIVE AND IN WHICH WE FIND IT EASIER OR HARDER TO MEET OUR NEEDS. YOU CAN THINK OF THE ENVIRONMENT AS A MIRROR WHICH SHOWS US WHO WE ARE, HOW OTHERS FEEL ABOUT US, HOW MUCH CONTROL WE HAVE OVER OUR LIVES AND FUTURES. FOR EXAMPLE, IF A CHILD IS OFTEN TOLD HE OR SHE IS GOOD LOOKING AND SMART, THAT CHILD WILL COME TO SEE HIM OR HERSELF AS GOOD LOOKING AND SMART. IF A CHILD IS OFTEN TOLD HE OR SHE IS GOOD FOR NOTHING, THAT CHILD IS LIKELY TO COME TO BELIEVE HE OR SHE CANNOT DO MUCH IN LIFE. HEALTHY ENVIRONMENTS HELP US BELIEVE IN OURSELVES. UNHEALTHY ENVIRONMENTS FILL US WITH DOUBT ABOUT OURSELVES. HEALTHY ENVIRONMENTS HELP US TO MEET OUR NEEDS. UNHEALTHY ENVIRONMENTS KEEP US FROM MEETING OUR NEEDS. UNMET NEEDS CREATE STRESS AND FEELINGS OF SELF DOUBT AND HELPLESSNESS.

Suicide prevention - building environments which make it easier to meet our needs;

designing programs which strengthen people's abilities to meet their needs;

learning to recognize the troubled, those who have unmet needs;

developing mechanisms for intervening to help the troubled.

There are many different kinds of approaches that can be used to build healthy environments and to prevent self-destructive behavior and suicide. The following page indicates just some of the many possibilities.

We can reduce the stresses caused by unmet needs through programs that build healthy environments.

STRESS	PROGRAM
boredom, meaninglessness	youth projects, community service projects
lack of adult/elder guidance	youth/elder projects
poor parenting	parenting classes
unclear sense of self	cultural pride projects
unclear sense of future, powerlessness	classes in goal setting, increasing opportunities

We can strengthen the skills needed to cope with stresses and challenges.

EDUCATIONAL PROGRAMS, SUCH AS LIFE SKILLS, REFUSAL SKILLS, PROBLEM SOLVING, GOAL SETTING, ETC. EMPLOYMENT AND SKILL ORIENTED CLASSES.

We can build support networks.

VARIOUS KINDS OF SUPPORT GROUPS SUCH AS HEALING CIRCLES, GROUPS FOR MOTHERS, FATHERS, MEN, WOMEN, AA, MOTHER-DAUGHTER, FATHER-SON, NATURAL HELPERS, ETC.

We can identify those who are troubled and at risk for self-destructive behavior sooner.

EDUCATIONAL PROGRAMS FOR TEACHERS, VILLAGE HELPERS. DEVELOPMENT OF REFERRAL PLANS AND AGREEMENTS WITH COMMUNITY MENTAL HEALTH CENTERS

We can provide better help for those who are troubled and at risk.

COMMUNITY RESOURCES PLUS LINKS TO AND TRAINING BY COMMUNITY MENTAL HEALTH CENTERS OR OTHER SERVICE PROVIDERS.

We can learn to recognize the warning signs of self-destructive behavior and offer better help sooner.

CRISIS RESPONSE TEAM TRAINING, COMMUNITY EDUCATION, LINKS TO AGENCIES.

We can provide effective help for those who behave in self-destructive ways.

PROGRAMS WITHIN THE COMMUNITY AND AGREEMENTS BETWEEN TREATMENT AGENCIES AND COMMUNITIES.

We can provide support and help for people who have lost relatives and friends.

SUPPORT GROUPS, EDUCATIONAL PROGRAMS.

ASSURANCES

Applicants must indicate their intention to comply with all terms and conditions of the RFP, the terms and conditions of any grant awarded by the Department and with 7 AAC 78, the Department's grant program regulations. These conditions include, but are not limited:

1. The provision of Worker's Compensation Insurance;

   The provision of automobile liability insurance if automobiles are used for the purposes of this grant program;

   The provision of comprehensive general liability insurance. If an applicant does not have liability insurance and acquiring such insurance would impose an undue hardship, the applicant may request a waiver from the Department. This request must be submitted in writing with a full justification including costs.

2. Compliance with the requirements of the Civil Rights Act of 1964, as amended.

3. Compliance with Federal and State laws and regulations relating to the prevention of discriminatory employment practices.

4. Compliance with Federal and State requirements for safeguarding information. Any information pertaining to clients of the Department that is encountered or developed under grant funds is confidential and cannot be released without the written approval of the Department.

5. Consent to Suit:
   Native Council applicants to the community-based suicide prevention grant program are required to consent to be sued by the State of Alaska upon any claims arising out of the Councils activities under that grant program. Consent to suit is a special condition of grant award to Native Councils.

6. Providing State officials access to financial and program records pertaining to the project and to the grant.

7. Maintenance of financial and program records for audit review.

8. Ensuring that grant funds will not be used for lobbying efforts.

9. Submission of quarterly fiscal and monthly program reports.

10. Cooperation with the program evaluation.

I _____, the Chief Executive Officer, President or

Chief of _____ hereby assure the
print or type name of entity apply for funds

Department of Health and Social Services that should my organization receive

Community-Based Suicide Prevention Funds it will comply with the

Assurances listed above.

_____ _____
Date Signature

_____
Title

BUDGET NARRATIVE

1. The BUDGET NARRATIVE describes the cost outlined in the BUDGET SUMMARY. See below.

2. Describe each item listed in each cost category. Indicate the funding source that will pay that cost (This Grant, Local, In-Kind, etc.).

3. If you plan to charge indirect costs, attach a copy of the most recent federally negotiated indirect cost agreement for your agency.

VILLAGE OF RURALTON
Elder/Youth Project

BUDGET NARRATIVE

100 PERSONAL SERVICES
Project Coordinator - This position provides overall direction for the project, works toward continued community input, writes and submits monthly and quarterly reports. This position works 15 hours per week; the total cost is $9,700 of which $7,200 is requested from this grant and $2,500 comes from the Village of Ruralton.
Fringe - The fringe benefits are 15% of the total salary and include federal withholding tax, social security tax, FUTA tax, and workman's compensation, for a total of $1,080.00.

200 TRAVEL
Project Coordinator to Anchorage - The purpose of this trip is to attend the Community-Based Suicide Prevention Program Coordinators Conference in order to assist the Village of Ruralton in planning and coordinating the project activities. Airfare at coach price is $320; per diem is $85/day times 4 days = $340 for a total cost of $660 requested from this grant.
Elder/Youth Travel - The purpose of these two trips is to send one Elder and one youth to Delta Village and one Elder and one youth to Yukon Village during the upcoming year to participate in educational and cultural exchanges. Airfare at coach price is $520 requested from this grant. Per diem of $1020 is contributed In-Kind from Delta Village and Yukon Village.

300 FACILITY
Rental - A building will be donated by the Village of Ruralton for this grant project at no cost to this grant. The In-Kind donation is $200/month x 10 months, the duration of the grant period.
Renovations - The building renovations consist of: $400 roof repair; $250 new bathroom sink and toilet; $200 interior and exterior paint; $250 shelving and cupboards; $100 replace broken windows; for a total of $1200 requested from this grant. Labor, estimated at $2500, will be donated by citizens of Ruralton.
Utilities/Phone - Electricity is estimated at $50/month x 10 months equals $500; heating fuel is estimated at $70/can x 12 cans = $840; long distance telephone charges are estimated at $50; for a total of $1390 requested from this grant.

(Over)

400 SUPPLIES

Office Supplies - estimated at $350; $150 is requested from this grant and $200 will be in-kind from the Village of Ruralton.

Program supplies - $250 educational video rentals and blank tapes; $150 paints, brushes, paint posters, pencils and drawing paper for artwork; $300 for beaver and rabbit skins; $100 for assorted yarns, sewing supplies for a total of $800 requested from this grant.

500 EQUIPMENT

Video Equipment consists of a TV and VCR for showing educational films and games for a total of $800 requested from this grant.

Storage Cabinet will ensure proper storage and security of films and games. Requested from this grant is estimated cost of $200.

We will get bids for these equipment items and submit the paperwork.

600 OTHER

Consultants will come to the village of Ruralton from the Regional Mental Health Center and other appropriate agencies. These agencies will conduct workshops at no cost to the Village or to this grant; the estimated value of services is $7,000.

Workshop Trainer - A special workshop on grieving and healing will be done by Kupier-Ross; $500 is requested from this grant to pay for her services; her airfare and per diem, $850, is donated by Delta Village and Yukon Village, who will also attend this workshop.

Stipends to Elders - $1,000 is requested from this grant for Elders to teach traditional crafts and skills to the youth of Ruralton.

700 INDIRECT

The Village of Ruralton will not charge an indirect cost to this grant.

VILLAGE OF RURALTON
Elder/Youth Project

BUDGET SUMMARY

Cost Category	This Grant	Local	In-Kind	Other	Total
100 PERSONAL SERVICES					
Project Director, 15/hrs/wk x $12/hr x 10 months	$ 7,200	$ 2,500			$ 9,700
Fringe @ 15%	1,080				1,080
Subtotal:	$ 8,280	$ 2,500			$10,780
200 TRAVEL					
Proj. Director to Anchorage					
Airfare	$ 320				$ 320
Per Diem $85 x 4 days	340				340
Elder/Youth to Delta Village x 2 trips:					
Airfare: 2 x $130 x 2 trips	520				520
Per diem $85 x 2 x 6 days			$ 1,020		1,020
Subtotal	$ 1,180		$ 1,020		$ 2,200
300 FACILITY					
Rental: $200/mo x 10 mos.			$ 2,000		$ 2,000
Renovations	$ 1,200		2,500		3,700
Electricity: $50/mo x 10 mos	500				500
Fuel: $70/can x 12 cans	840				840
Telephone: Long Distance	50				50
Subtotal:	$ 2,590		$ 4,500		$ 7,090
400 SUPPLIES					
Office Supplies	$ 150		$ 200		$ 350
Program Supplies	800				800
Subtotal:	$ 950		$ 200		$ 1,150
500 EQUIPMENT					
Video Equipment	$ 800				$ 800
Storage Cabinet	200				200
Subtotal:	$ 1,000				$ 1,000
600 OTHER					
Consultants			$ 7,000		$ 7,000
Workshop Trainer	$ 500		850		1,350
Stipends to Elders	1,000				1,000
Subtotal:	$ 1,500		$ 7,850		$ 9,350
700 INDIRECT					
None					
TOTAL BUDNARR.DOC	$15,500	$ 2,500	$13,570		$31,570